Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
AHMED KHALIFA, MD

Respondent Name
LIBERTY MUTUAL INSURANCE CO

MFDR Tracking Number
M4-15-3552-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
JUNE 25, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a request for reconsideration to Liberty Mutual on 4-17-15, this request was in response to a $174.76 reduction of the $562.36 for the Injection performed on 8-26-14."

Amount in Dispute: $1174.76

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The claim for [Claimant] injury on [date of injury] is under the jurisdiction of the state of New Jersey."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 26, 2014	CPT Code 27096-50 Bilateral Sacroiliac Joint Injection	$174.76	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, effective May 25, 2008, 33 *Texas Register* 3954, sets out the procedures for resolving a medical fee dispute.
2. Texas Labor Code §406.075, effective September 1, 1993, prohibits claims from other workers compensation jurisdictions from seeking benefit in the Texas Workers Compensation
3. 28 Texas Administrative Code §134.203 set out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - P300-The amount paid reflects a fee schedule reduction.
   - M445-Original fee schedule value has been increased according to the state guidelines.
   - Z710-The charge for this procedure exceeds the fee schedule allowance.

Issues

1. Does Medical Fee Dispute Resolution have jurisdiction to review this dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent contends that this is not eligible for medical fee dispute resolution because it is a New Jersey Workers' Compensation claim.

   Texas Labor Code §406.075(a) states "An injured employee who elects to pursue the employee 's remedy under the workers ' compensation laws of another jurisdiction and who recovers benefits under those laws may not recover under this subtitle."

   A review of the submitted documentation fins that the respondent did not submit documentation to support position that this is a New Jersey claim; therefore, the dispute will be reviewed per the Division's applicable rules and guidelines.

2. According to the submitted explanation of benefits, the respondent issued payment of $387.60 for code 27096-50 based upon reason codes "P300" and "Z710."

   28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   CPT code 27096 is defined as "Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed."

   The requestor appended modifier "50-Bilateral Procedure" to code 27096.

   Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   Place of Service is 11-Office Based.

   The 2014 DWC conversion factor for this service is 55.75.

   The Medicare Conversion Factor is 35.8228

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 77042, which is located in Houston, Texas; therefore, the Medicare participating amount is based on locality "Houston Texas".

   Medicare Participating amount for code 27096 is $166.05.

   Using the above formula, the Division finds the following: MAR is $258.42 multiplied by 150% because bilateral procedure = $387.60. The respondent paid $387.60. As a result, reimbursement of $0.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	08/17/2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.